Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-10-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, therapeutic exercises, neuromuscular re-education, manual techniques and electrical stimulation **were** found to be medically necessary. The DME **was not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 7th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 01-13-04 through 04-27-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 7th day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh
Enclosure: IRO decision

December 28, 2004

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT:
EMPLOYEE:
POLICY: M5-05-0838-01
CLIENT TRACKING NUMBER: M5-05-0838-01/5278

AMENDED REVIEW

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above-mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

Records from the State
Notification of IRO Assignment dated 12/9/04
Medical Dispute Resolution Request/Response dated 11/10/04
Table of disputed services dated 1/13/04 to 4/27/04
Explanation of review dated 2/5/04 to 5/18/04

Records from Requestor
Medical record review dated 5/8/03
Initial Therapy Evaluation dated 12/4/03
Daily progress notes dated 11/11/03 to 12/17/03
Initial Medical Report dated 5/29/03
Subsequent Medical Report dated 6/1/04
Radiology report dated 5/20/04
Operative report dated 5/20/04
Follow-up note dated 4/8/04
MRI Lumbar spine without contrast dated 1/9/03

Letter from Guy Fogel, MD to William Hicks, DC dated 3/11/04
Comprehensive Pain Follow-up dated 2/17/04
Comprehensive Pain Consultation dated 11/4/03
Daily progress notes dated 1/13/04 to 8/4/04

Summary of Treatment/Case History:
The patient ___, is reported as falling/jumping from a block on a job site at which he was employed for two years as a masonry/bricklayer while he was holding a 25 pound cement block to avoid being hit by a forklift that was moving a scaffold in his direction, he reported immediate pain and a popping noise at the time of the occupational injury. Patient presents with anterior spondylosis at the L3-L4 level 3mm L3-L3 disk bulge, 3-4 mm parasagittal subligamentous herniation L4-L5 that is compressing the right transverse L5 nerve root and thecal sac, prominent anterior epidural veins transversing the entire spine enhancing the L5 nerve root and thecal sac compression. Treatment summary from 1-23-04 thru 4-27-04, with visits being spread out from 7 days to 10 days plus apart with intermittent variation of interval, includes electrical stim, manual therapy, therapeutic exercises, neuro muscular re-education, undisclosed DME. General coding is unknown as to what DME was given.

Questions for Review:
The question was stated as the medical necessity for the office visits, #97032 (electric stim), #97140 (manual techniques), #97110 (therapeutic exercises), #97112 (neuro muscular re-education) and #E1399 (DME). Dates of dispute are from 1-13-04 thru 4-27-04.

Explanation of Findings:
Given the nature of the injury/incident and the test findings presented in this case both the treatment time, and modalities are both reasonable and prudent for this injury. This patient has documented significant injuries that need care over a lengthy period of time. Due to underlying factors that may be present, continued care over this length of time using these modalities is within the boundaries of care. These are significant injuries and may need additional extended follow up care to maintain a reduced pain state while working towards stabilizing the injury, using exactly that of #97710, #97112, and #97032.

Conclusion/Decision to Certify:
Decision is to certify as medically necessary all office visits (#99212), #97110, #97112, #97140 and #97032 for the time period of 1-13-04 thru 4-27-04.

Conclusion/Decision to Not Certify:
Decision not to certify #E1399 for undisclosed DME.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:
Extensive disk injuries may take extended healing times and treatments. Pain interventions along with tissue management for inflammation that is repeated and continued can yield the best results. In cases of root compressions coupled with other significant underlying and contributing factors one can expect longer delays in recovery.

References Used in Support of Decision:
Rehab of the Spine – Lieberman
Fundamentals of Diagnosis and Treatment – Lawrence
Applied Physiotherapy – Jaskoviak

The physician providing this review is board certified in chiropractic medicine. The reviewer also holds additional certifications in Acupuncture and Orthopedics. The reviewer is a member of their state chiropractic association and is certified to provide reviews for the workers compensation commission as a designated doctor, RME and IME. The reviewer has been in active practice since 1998.
MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

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